
MTN Health Insurance, LLC

303-594-1939

To apply for this policy or for more information please go to:

<http://mtnhealthinsurance.com>

Colorado Health Benefit Plan Description Form

Time Insurance Company

Short Term Medical Healthsaver

PART A: TYPE OF COVERAGE

1. TYPE OF PLAN	Medical Expense Policy
2. OUT-OF-NETWORK CARE COVERED? ¹	Yes; policy makes no distinction between in-network and out-of-network care.
3. AREAS OF COLORADO WHERE PLAN IS AVAILABLE	Plan is available throughout Colorado

PART B: SUMMARY OF BENEFITS

Important Note: This form is not a contract, it is only a summary. The contents of this form are subject to the provisions of the policy, which contains all terms, covenants and conditions of coverage. Your plan may exclude coverage for certain treatments, diagnoses, or services not noted below. The benefits shown in this summary may only be available if required plan procedures are followed (e.g., plans may require prior authorization, a referral from your primary care physician, or use of specified providers or facilities). Consult the actual policy to determine the exact terms and conditions of coverage. Coinsurance and copayment options reflect the amount the covered person will pay.

	BENEFIT LEVELS
4. Deductible Type ²	Calendar Year
4a. ANNUAL DEDUCTIBLE ^{2a} a.) Individual ^{2b} b.) Family ^{2c}	a.) \$1,000, \$2,500, \$5,000 or \$7,500 b.) \$3,000, \$2,500, \$5,000 or \$7,500
5. OUT-OF-POCKET ANNUAL MAXIMUM ³ a.) Individual b.) Family c.) Is deductible included in the out-of-pocket maximum?	Out-of-pocket does not include deductible a.) 80% coinsurance = \$2,000 out-of-pocket 50% coinsurance = \$5,000 out-of-pocket b.) \$10,000 c.) No Outpatient Services maximum is \$2,000 per Benefit Period (Does not include deductible)
6. LIFETIME OR BENEFIT MAXIMUM PAID BY THE PLAN FOR ALL CARE	\$100,000
7A. COVERED PROVIDERS	All providers licensed or certified to provide covered benefits.
7B. With respect to network plans, are all the providers listed in 7A accessible to me through my primary care physician?	Not applicable. This is not a network plan.
8. MEDICAL OFFICE VISITS ⁴ a.) Primary Care Providers b.) Specialists	Office visits with Primary Care Providers and Specialists are subject to deductible; coinsurance. Office visits for preventive/wellness services are not covered.

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9. PREVENTIVE CARE	
a.) Children's Services	Deductible waived; coinsurance
b.) Adults' Services	Mammogram; no deductible.
10. MATERNITY	
a.) Prenatal Care	Not covered except for complications.
b.) Delivery & inpatient well baby care ⁵	Not covered.
11. PRESCRIPTION DRUGS ⁶ Level of coverage and restrictions on prescriptions.	Not covered
12. INPATIENT HOSPITAL	Deductible; coinsurance
13. OUTPATIENT/AMBULATORY SURGERY	Deductible; coinsurance
14. DIAGNOSTICS	Deductible; coinsurance
a.) Laboratory & x-ray	
b.) MRI, nuclear medicine, and other high-tech services	
15. EMERGENCY CARE ^{7 8}	Deductible; coinsurance. Emergency care charges are subject to the Outpatient Services Maximum if claims are billed by the provider as outpatient.
16. AMBULANCE	Deductible; coinsurance; one trip per illness or injury
17. URGENT, NON-ROUTINE, AFTER HOURS CARE	Deductible; coinsurance
18. BIOLOGICALLY-BASED MENTAL ILLNESS CARE ⁹	Coverage is no less extensive than the coverage provided for any other physical illness.
19. OTHER MENTAL HEALTH CARE	
a.) Inpatient Care	Not covered
b.) Outpatient Care	Not covered
20. ALCOHOL & SUBSTANCE ABUSE	Not covered
21. PHYSICAL, OCCUPATIONAL, & SPEECH THERAPY	Deductible; coinsurance; 10 visit maximum per benefit period
22. DURABLE MEDICAL EQUIPMENT	Deductible; coinsurance; See policy for types of and circumstances of coverage.
23. OXYGEN	Deductible; coinsurance
24. ORGAN TRANSPLANTS	Not covered

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25. HOME HEALTH CARE	Deductible; coinsurance; 40 visits maximum per calendar year.
26. HOSPICE CARE	Deductible; coinsurance; 30 days maximum per benefit period
27. SKILLED NURSING FACILITY CARE	Deductible; coinsurance; 30 days maximum per benefit period
28. DENTAL CARE	Deductible; coinsurance; Coverage is limited to hospital inpatient care required due to injury. Only the hospital charges are covered.
29. VISION CARE	Not covered
30. CHIROPRACTIC CARE	Deductible; coinsurance; 10 visit maximum per benefit period
31. SIGNIFICANT ADDITIONAL COVERED SERVICES (list up to 5)	Temporomandibular Joint (TMJ) and Craniomandibular Joint (CMJ) Dysfunction; \$1,000 maximum per benefit period.

PART C: LIMITATIONS AND EXCLUSIONS

32. PERIOD DURING WHICH PRE-EXISTING CONDITIONS ARE NOT COVERED ¹⁰	12 months for all pre-existing conditions.
33. EXCLUSIONARY RIDERS. Can an individual's specific, pre-existing condition be entirely excluded from the policy?	Yes
34. HOW DOES THE POLICY DEFINE A "PRE-EXISTING CONDITION"?	A pre-existing condition is an injury, sickness or pregnancy for which a covered person incurred charges, received medical treatment, consulted a health care professional, or took prescription drugs within 12 months immediately preceding the effective date of coverage.
35. WHAT TREATMENTS AND CONDITIONS ARE EXCLUDED UNDER THIS POLICY?	Exclusions vary by policy. A list of exclusions is available immediately upon request from your carrier or agent. Review the list to see if a service or treatment you may need is excluded from the policy.

Part D: USING THE PLAN

36. Does the enrollee have to obtain a referral and/or prior authorization for specialty care in most or all cases?	Yes
37. Is prior authorization required for surgical procedures and hospital care (except in an emergency)?	Yes
38. If the provider charges more for a covered service than the plan normally pays, does the enrollee have to pay the difference?	Yes
39. What is the main customer service number?	1-800-800-2412
40. Whom do I write/call if I have a complaint or want to file a grievance? ¹¹	Assurant Health P.O. Box 3089 Milwaukee, WI 53201 800-800-2412
41. Whom do I contact if I am not satisfied with the resolution of my complaint or grievance?	Write to: Colorado Division of Insurance ICARE Section 1560 Broadway, Suite 850 Denver, CO 80202

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42. To assist in filing a grievance, indicate the form number of this policy, whether it is individual, small group, or large group; and if it is a short-term policy.	Policy Form Number: 136.CO HealthSaver Short Term Policy
43. Does the plan have a binding arbitration clause?	No

Endnotes

1	“Network” refers to a specified group of physicians, hospitals, medical clinics and other health care providers that your plan may require you to use in order for you to get any coverage at all under the plan, or that the plan may encourage you to use because it may pay more of your bill if you use their network providers (ie., go in-network) than if you don’t (i.e., go out-of-network).
2	“Deductible Type” indicates whether the deductible period is “Calendar Year” (January 1 through December 31) or “Benefit Year” (i.e., based on a benefit year beginning on the policy’s anniversary date) or if the deductible is based on other requirements such as a “Per Accident or Injury” or “Per Confinement”.
2a	“Deductible” means the amount that you will have to pay for allowable covered expenses under a health plan during a specified time period (e.g., a calendar year or benefit year) before the carrier will cover those expenses. The specific expenses that are subject to deductible may vary by policy. Expenses that are subject to deductible should be noted in boxes 8 through 31.
2b	“Individual” means the deductible amount you and each individual covered by a non-HSA qualified policy will have to pay for allowable covered expenses before the carrier will cover those expenses. “Single” means the deductible amount you will have to pay for allowable covered expenses under an HSA-qualified health plan when you are the only individual covered by the plan.
2c	“Family” is the maximum deductible amount that is required to be met for all family members covered by a non-HSA qualified policy and it may be an aggregated amount (e.g., “\$3,000 per family”) or specified as the number of individual deductibles that must be met (e.g., “3 deductibles per family”). “Non-single” is the deductible amount that must be met by one or more family members covered by an HSA-qualified plan before any covered expenses are paid.
3	“Out-of-pocket maximum” means the maximum amount you will have to pay for allowable covered expenses under a health plan, which may or may not include the deductibles or copayments, depending on the contract for that plan. The specific deductibles or copayments included in the out-of-pocket maximum may vary by policy. Expenses that are applied toward the out-of-pocket maximum should be noted in boxes 8 through 31.
4	Medical office visits include physician, mid-level practitioner, and specialist visits, including outpatient psychotherapy visits for biologically based mental illness.
5	Well baby care includes an in-hospital newborn pediatric visit and newborn hearing screening. The hospital copayment applies to mother and well-baby together; there are not separate copayments.
6	Prescription drugs, otherwise excluded are not covered, regardless of whether preferred generic, preferred brand name, or non-preferred.
7	“Emergency care” means all services delivered in an emergency care facility that are necessary to screen and stabilize a covered person. The plan must cover this care if a prudent lay person having average knowledge of health services and medicine and acting reasonably would have believed that an emergency medical condition or life or limb threatening emergency existed.
8	Non-emergency care delivered in an emergency room is covered only if the covered person receiving such care was referred to the emergency room by his/her carrier or primary care physician. If emergency departments are used by the plan for non-emergency after-hours care, then urgent care copayments apply.
9	“Biologically based mental illnesses” means schizophrenia, schizoaffective disorder, bipolar affective disorder, major depressive disorder, specific obsessive-compulsive disorder, and panic disorder.

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10	Waiver of pre-existing condition exclusions. State law requires carriers to waive some or all of the pre-existing condition exclusion period based on other coverage you recently may have had. Ask your carrier or plan sponsor (e.g., employer) for details.
11	Grievances. Colorado law requires all plans to use consistent grievance procedures. Write the Colorado Division of Insurance for a copy of those procedures.

"Colorado law requires carriers to make available a Colorado Health Benefit Plan Description Form, which is intended to facilitate comparison of health plans. The form must be provided automatically within three (3) business days to a potential policyholder who has expressed interest in a particular plan or who has selected the plan as a finalist from which the ultimate selection will be made. The carrier also must provide the form, upon oral or written request, within three (3) business days, to any person who is interested in coverage under or who is covered by a health benefit plan of the carrier."